<u>Division</u>	of Health Care Fac	cilities			FORM	APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
<u></u>		TN0802	B. WING		07/5	M2043	
NAME OF PROVIDER OR SUPPLIER STREET			ADDRESS, CITY, STATE, ZIP CODE		1 07/2	07/24/2013	
LIFE CAP	RE CENTER OF CLE	VELAND 3530 KE	ITH ST NW AND, TN 3731				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDERS PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		HOULD BE COMPLETE		
N 000	Initial Comments		N 000				
	July 24, 2013, at Li No deficiencies we	re survey was completed on ife Care Center of Cleveland. re cited under Chapter ds for Nursing Homes.					
		•					
, 2-2	Photography - Comments (pr. Euro, computer major contribut	and Constructive State Section (1997) and the Constructive State Section		agang galanan mengalangkan, bada ara — 4 p. Jan dalah dalah galangkan mengalangkan mengalangkan mengalangkan m	**		
		•				j	
						:	
;		·					
vision of He BORATORY	aith Care Facilities DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	I	TITLE		(X8) DATE	
ATE FORM	···-		6600 N.S	FK11	ff nametin and	on sheet 1 of	